

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **882**
Registrar's No. **8**

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 5465		Registrar's No. 8	
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene			
b. CITY OR TOWN Springfield Rural N Campbell Twsp		c. LENGTH OF STAY (In this place) 4 years		c. CITY OR TOWN Springfield Rural N Campbell Twsp		0390	
d. FULL NAME OF HOSPITAL OR INSTITUTION Warnick Rest Home, College St Rd				d. STREET ADDRESS W. Hwy #66 College St Road, Route #4			
3. NAME OF DECEASED (Type or Print) a. (First) Fred		b. (Middle) M		c. (Last) Jones		4. DATE OF DEATH (Month) (Day) (Year) January 2 1951	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb 9, 1878	
9. AGE (In years last birthday) 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator		10b. KIND OF BUSINESS OR INDUSTRY Frisco Railroad		11. BIRTHPLACE (State or foreign country) Jamestown, N Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Rose M Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter H Henderson, Springfield, Missouri			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage Cerebral ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 4 DUE TO (c) 1 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Jan 1946 Jan. 2 1949	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-8-1946 to 1-2-1951 that I last saw the deceased alive on 1-1-1951 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. H. Henderson		23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 1-2-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan 5, 1951		24c. NAME OF CEMETERY OR CREMATORY Lebanon City Cem		24d. LOCATION (City, town, or county) (State) Lebanon, Missouri	
DATE REC'D BY LOCAL REG. 1-4-51		REGISTRAR'S SIGNATURE W. E. Hardy M.D.		FUNERAL DIRECTOR'S SIGNATURE Alma Schmeier		ADDRESS Springfield, Mo	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 25 1957

MAR 9 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4707

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.